STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 11, 12, 13, 14, & 15, 2011. Facility number: 000282 Provider number: 155755 AIM number: 000287520 Survey team: Sue Brooker, RD-TC Rick Blain, RN Sheryl Roth, RN Angie Strass, RN Census bed type: SNF/NF: 103 Total: 103 Census payor type: Medicare: 4 Medicaid: 79 Other: 20 Total: 103 Sample: 21 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Ms. Kim Rhoades Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204Dear Ms. Rhoades: Please find our Plan of Correction for our Annual Survey conducted in our community July 11-15, 2011. Our date of compliance is August 13, 2011. Please contact me if you need any further information or details. Sincerely, Dianna Holmes, MSW, HFA Administrator The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after August 13, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on July 18, 2011 by Bev Faulkner, RN			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure an incident of physical abuse did not occur for 1 of 21 residents reviewed for abuse in a sample of 21. (Resident #104) Findings include: Resident #104's record was reviewed on 7/14/11 at 8:45 a.m. The record indicated Resident #104's diagnoses included, but were not limited to, high blood pressure, chronic obstructive pulmonary disease, Alzheimer's Dementia and hypothyroidism. "Nurse's Notes" for Resident #104, dated 5/17/11 at 8:00 p.m., indicated the resident was given a shower by two care	F0223	F 0223It is the practice of this provider to ensure residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This provider does not allow verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** This resident is no longer in the facility.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**The employees were immediately terminated therefore no other residents had the potential to be affected by the	08/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	givers. During the shower, the resident indicated "Look what they did to me" and showed the caregivers her right hand/wrist bruise. The resident then indicated "they held her arms down". Both caregivers indicated the resident was combative and had scratched the caregivers arms. The "Facility Incident Reporting Form," dated 5/18/11, indicated "...resident reported to (name of staff)...that employees (name of employee) and (name of employee) continued giving her a shower despite resident becoming agitated and wanting to not continue to shower...Resident reported 'They held my arms down...Those 2 young girls did that to me'...Resident was combative during shower...Resident is on daily aspirin, has fragile skin...Resident sustained purple bruising on right bilateral hand, wrist and lower forearm in six areas...(name of staff) immediately suspended...gave written statements prior to departure with neither admitting to holding down resident's arm...both confirmed she was combative and choosing unsafe decisions in attempting to get out of shower...CNA's terminated per policy of zero tolerance for any accusations of abuse or neglect substantiated or unsubstantiated...." During an interview with the Health Facility Administrator (HFA) on 7/15/11		alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** This provider's system is as follows: Pre-employment interviews are conducted, Pre-employment reference checks are conducted, Employment criminal background checks are completed, Employees are trained upon hire and routinely thereafter on abuse and neglect policy and procedure, Proper authorities are notified of abuse and neglect allegations, This provider has a zero tolerance for abuse and neglect, therefore any allegations of such incidents will warrant immediate termination. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** All staff will be in-serviced by the Administrator and/or Director of Nursing Services or designees on July 28 and August 1, 2011 regarding this provider's abuse and neglect policy and procedure, caring for combative residents and resident rights. Administrator or designee will monitor continued compliance through monthly random employee interviews and observations regarding our abuse and neglect policy, caring for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 9:00 a.m., the HFA indicated both staff members were terminated due to the zero tolerance by the facility on abuse. 3.1-27(a)(1)		combative residents and resident' s rights x 6 months. The Administrator will document findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) Assessment for 2 of 21 residents related to eating (Resident #91 and #104) and failed to accurately code the MDS for bed mobility for 1 of 21 residents reviewed for bed mobility (Resident #88) in a sample of 21. Findings include:	F0278	It is the practice of this provider to complete assessments that accurately reflect the resident's status. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals. A registered nurse signs and certifies the assessment is completed. Each individual who completes a portion of the assessment signs and certifies the accuracy of that portion of the assessment.What corrective action(s) will be	08/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Resident #88's record was reviewed on 7/11/11 at 2:05 p.m. The record indicated Resident #88's diagnoses included, but were not limited to, high blood pressure, heart disease and fractured hip. The quarterly Minimum Data Set (MDS) Assessment, dated 6/1/11, indicated Resident #88 performed bed mobility only once or twice during the one week observation period. The "ADL Grid" (activities of daily living), dated 5/26/11 through 6/1/11, indicated Resident #88 was independent for bed mobility 7 of 7 times on nights, 7 of 7 times on days, and 6 of 7 times on evenings. 2. Resident #104's record was reviewed on 7/14/11 at 8:45 a.m. The record indicated Resident #104's diagnoses included, but were not limited to, high blood pressure, Alzheimer's dementia and chronic obstructive pulmonary disease. The significant change MDS, dated 3/1/11, indicated Resident #104 participated in eating only once or twice during the one week observation period. The narrative report for the 3/1/11 MDS indicated Resident #104 continued on a no added salt diet which she would feed to herself after set up by staff.		accomplished for those residents found to have been affected by the deficient practice?Residents #88, #91 and #104 's most recent MDS's were audited, modified if required and resubmitted. All were accepted upon resubmission. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?100% of our residents latest MDS's that were previously transmitted have been audited, modified if required and resubmitted. All were accepted upon resubmission.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Our MDS Coordinator contacted Barb Wheeler, State of Indiana RAI Coordinator, for further clarification, training and guidance on the issues identified. We completely understand this part of the system therefore will not have a reoccurence of the alleged deficient practice. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Our MDS Coordinator will audit monthly x 6 months the four late loss ADL's on all transmitted MDS's to be certain of accuracy. The Administrator will document	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The "ADL Grid," dated 2/23/11 through 3/1/11, indicated Resident #104 was independent with eating 6 of 7 times on days and required only supervision on 1 of 7 days. The "ADL Grid" for evenings, indicated the resident was independent with eating on 6 of 7 times on evenings and required comprehensive assistance for 1 of 7 times on evenings. 3. Resident #91's record was reviewed on 7/13/11 at 1:50 p.m. The record indicated Resident #91's diagnoses included, but were not limited to, depression, chronic obstructive pulmonary disease and coronary artery disease. The significant change MDS, dated 4/26/11, indicated Resident #91 participated in eating only once or twice during the one week observation period. The narrative report for the 4/26/11 MDS indicated Resident #91 continued on a no added salt diet which she ate in the unit dining room. The "ADL Grid," dated 4/20/11 through 4/26/11, indicated Resident #91 was independent with eating 7 of 7 times during the day. The "ADL Grid" for evenings, indicated the resident was independent with eating 5 of 7 times and required limited assistance 2 of 7 times on		findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evenings. The "Activities of Daily Living (ADL) Assistance (Algorithm), dated September 2010, indicated "...When an activity occurs three times at any one given level, code that level...." During an interview with the MDS nurse on 7/15/11 at 9:56 a.m., the MDS nurse indicated the coding she used was how she was trained when the program was first introduced. 3.1-31(d)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure medications were not left unattended during a medication pass in the Maple Cove dining room, potentially affecting 4 of 4 residents seated at the table (Resident #29, Resident #32, Resident #33, Resident #38). Findings include:	F0323	It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #29, #32,	08/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation of a medication pass by Nurse #2 on 7/12/11 at 4:45 P.M., on the Maple Cove unit (secured memory care unit), the nurse was observed to place oral medications into a paper medication cup for Resident #29. Nurse #2 was observed to take the medication cup to the table where Resident #29, Resident #32, Resident #33, and Resident #38 were seated and then leave the cup on the table. At that time, Nurse #2 indicated that he left the medications at the table because Resident #29 would take them when she felt ready. Two other staff were observed to be in the dining room passing plates and assisting residents at other tables. At 4:50 P.M.,Nurse #2 was observed to leave the Maple Cove Unit to continue the medication pass on another unit. The oral medications for Resident #29 were still in the paper medication cup Nurse #2 had placed at her table. The Unit Manager of Maple Cove, Nurse #3, was interviewed on 7/14/11 at 10:40 A.M. During the interview, Nurse #3 indicated there were no residents on Maple Cove capable of self administration of medications. Nurse #3 further indicated nurses administering medications were to remain with the resident and observe the resident until the		#33 and #38 had no negative outcomes as a result of the alleged deficient practice. Nurse #2 received one on one written training with the DNS and Community Nurse Leader on July 15, 2011. He has since resigned.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**It is against Golden Years Homestead's policy and procedure for licensed nurses to leave medications unattended after administration therefore all residents who are not self-administration of medications are at risk.Nurse #2 received one on one written training with the DNS and Community Nurse Leader on July 15, 2011. He has since resigned.All licensed nurses will be in-serviced by the Director of Nursing Services or designees on July 28 and August 1, 2011 regarding this provider's policy and procedure for "Administration of Oral Medication". **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Director of Nursing or designees will train all newly hired Licensed Nurses on this provider's policy and procedure for "Administration of Oral Medication". All licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident swallowed the medication. She further indicated medications were not to be left with the resident unattended. The facility Director of Nursing (DON) was interviewed 7/14/11 at 11:00 A.M. During the interview, the DON indicated all residents on Maple Cove were cognitively impaired and none were capable of self administration of medications. The DON further indicated nurses administering medications were to stay with the resident and observe the resident until the medications were swallowed. The records for Resident #29, Resident #32, Resident #33, and Resident #38 were reviewed on 7/13/11 from 1:00 P.M. to 1:30 P.M. The records indicated all the residents had a diagnosis of dementia. A facility entitled "Administration of Oral Medication", dated July 2011, indicated "do not leave medications unattended." 3.1-45(a)(1)		nurses will be in-serviced by the Director of Nursing Services or designees on July 28 and August 1, 2011 regarding this provider's policy and procedure for "Administration of Oral Medication". **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administrator, Director of Nursing Services or designee will monitor continued compliance through monthly random licensed nurse medication pass observations x 6 months. The Administrator will document findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based observation, record review, and interview, the facility failed to prevent potential contamination of food by failing to ensure dietary staff properly washed their hands for the recommended amount of time during meal service and prior to donning disposable gloves. The facility also failed to ensure dietary staff washed their hands when moving from a soiled area to a clean area, used a clean towel to dry out the canister of a clean blender and also ensure dietary staff did not chew gum during meal service in 4 of 4 kitchens potentially affecting 103 of 103 residents who ate meals prepared and served in the facility kitchens. Findings include: 1. On 7/11/11 from 11:15 A.M. until 12:45 P.M., the following observations were made in the kitchen of the B Unit: At 11:15 A.M., Cook #5 was observed to remove gloves and reach into a bucket of sanitizing solution, remove a cloth, and	F0371	**It is the practice of this provider to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? There were no negative outcomes to any resident as a result of the alleged deficient practice.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by the alleged deficient practice.**All employees involved in food service operations will be in-serviced by the Administrator, Culinary Services Advisor and Registered Dietician on July 26, July 28 or August 1 and August 2, 2011. In-Service topics will be: Alleged deficient practices identified, Proper Culinary Services hand	08/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wipe the surface of a metal serving cart. Cook #5 was then observed to wipe his hands with the same cloth, don gloves, and begin dishing food onto plates with scoops. Cook #5 was not observed to wash hands prior to donning the gloves. At 11:20 A.M., Aide #4 was observed to use a cloth to wipe a counter surface. Aide #4 was then observed to remove a clean blender canister from the dishwashing machine. The blender canister had some soap bubbles on the outside and inside of the blender canister. Aide #4 was then observed to wipe the outside and inside of the blender canister with the same cloth that had been used to wipe off the counter surface. Cook #5 was then observed to use the blender canister to prepare pureed meat for one resident. At 11:25 A.M., Cook #5 was observed to open the oven door while wearing gloves and remove a pan of mashed potatoes. Cook #5 was then observed to handle several plastic meal cards while wearing the gloves. Cook #5 was then observed to open a plastic bag of dinner rolls and, by directly handling the rolls with the same gloves, remove the rolls from the bag and place the rolls onto plates for 18 of 20 residents.		washing policy and procedure, glove usage policy and procedure, including proper procedure when moving from a soiled area to a clean area, towel/rag usage, dress code policy and procedure to include no gum chewing. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All employees involved in food service operations will be in-serviced by the Administrator, Culinary Services Advisor and Registered Dietician on July 26, July 28 or August 1 and August 2, 2011. Culinary Services Advisor will provide on the job training and teaching to each food service employee as needs are identified. Registered Dietician will complete monthly observations and on the job training to those employees working during her visits. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administrator, Culinary Services Advisor, Registered Dietician or designees will monitor continued compliance through no less than monthly random kitchen audits and employee observations regarding the topics trained during the in-services x 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2 On 7/12/11 at 4:40 p.m., in the "D" kitchen, Dietary Cook #14 was observed leaving the food serving line with gloves on. The cook went to the cooler and retrieved items for making a resident sandwich: meat, cheese, bread, etc. Dietary Cook #14 then removed gloves and performed a four second hand wash before returning to the food serving line. Also, Dietary Cook #15 was observed washing hands directly under the water for six seconds before preparing to serve supper to the residents. 3. During an observation of the evening meal on 7/12/11, the following observations were made in the "C" kitchen: At 4:19 p.m., Cook #8 was observed to wash her hands for 8 seconds before donning disposable gloves to continue preparation for the evening meal. At 4:25 p.m., Aide #9 was observed to enter the kitchen. She was observed to wash her hands for 6 seconds.		The Administrator will document findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

At 4:28 p.m., Cook #8 was observed to was her hands for 7 seconds. She then donned a pair of disposable gloves and immediately began dishing food onto plates for the evening meal.

4. During an observation of the evening meal on 7/12/11, the following observation were made in the "A" kitchen:

At 4:45 p.m., Cook #10 was observed to leave the kitchen and come into the dining room to talk with a resident. She was observed to place her gloved hands on the table. She immediately returned to the kitchen to dish food onto a plate for the evening meal. She was not observed to remove her disposable gloves and wash her hands before continuing meal service.

At 4:47 p.m., Aide #11 was observed assisting in the kitchen with the evening meal service. He was observed chewing gum.

At 4:50 p.m., Aide #11 was observed to take a covered evening meal tray to a resident room on Cherry Park (a neighborhood on the "A" unit). He was observed to return to the kitchen to continue assisting with the evening meal service. He was not observed to wash his hands and was observed chewing gum.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At 4:52 p.m., Cook #10 was observed to return to the kitchen after being in a common hallway in the "A" unit. She was not observed to wash her hands, but immediately prepared an individual serving of green peas by opening up the freezer and placing the frozen peas into a container and then placing the container into the microwave to cook. She was then observed to dish 8 servings of baked apples into dessert dishes. No hand wash was observed. At 4:55 p.m., Aide #11 was observed to take a covered evening meal tray to a resident room on Cherry Park. He was observed to return to the kitchen and prepared a cup of coffee and a glass of juice to deliver to a resident's room. He was not observed to wash his hands and was observed chewing gum. At 4:57 p.m., Cook #10 started the evening meal service for the Chestnut dining room (a neighborhood on the "A" unit). She had not been observed to wash her hands at any time since the observation began at 4:45 p.m. Aide #11 also had not been observed to wash his hands at any time since the observation began at 4:45 p.m. He was observed to chew gum throughout the observation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Dietary Manager was interviewed on 7/14/11 at 12:40 p.m. During the interview, he indicated dietary staff were to wash their hands upon entrance into the kitchen and after touching anything soiled. He also indicated disposable gloves were not to be a substitute for handwashing. Hands were to be wet, lathered out of the water for 20 seconds, and then rinsed. He further indicated dietary staff were not to chew gum. A current facility policy "Hand Hygiene for Culinary Services Team Members", dated January 2011, indicated "...Before starting to work in a household kitchen, team members will perform the following: ...Vigorously generate friction on all surfaces of the hands and exposed arms including finger tips, areas between fingers, and backs of hands for 20 seconds...Hand washing will be performed: ...After handling soiled equipment or utensils...Before putting on gloves for working with food...." A current facility policy "Dress Code", dated June 2009, indicated "...All employees must abide by the following: ...No gum chewing...." 3.1-21(i)(2) 3.1-21(i)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0386 SS=D	The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on record review and interview, the facility failed to ensure the physician signed and dated all physician orders for 2 of 21 residents reviewed for physician orders in a sample of 21. (Resident #104 and #91) Findings include: 1. Resident #104's record was reviewed on 7/14/11 at 8:45 a.m. The record indicated Resident #104's diagnoses included, but were not limited to, high blood pressure, chronic obstructive pulmonary disease, Alzheimer's Dementia and hypothyroidism. During record review, the monthly physician orders summary for December	F0386	**It is the practice of this provider to have physicians review each resident's program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an aseesment for contraindications.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #91 and #104 had no negative outcomes as a result of the**	08/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2010, for Resident #104, were signed but not dated by the physician. During record review, the following monthly physician orders summary were unsigned by the physician: February 2011, March 2011, April 2011, May 2011, and June 2011. 2. Resident #91's record was reviewed on 7/13/11 at 1:50 p.m. The record indicated Resident #91's diagnoses included, but were not limited to, depression, chronic obstructive pulmonary disease, coronary artery disease, chronic kidney disease, high blood pressure and spinal stenosis. During record review for Resident #91, the following physician orders were signed but not dated by the physician: 6/16/11 order for ointment medication 6/21/11 order for anxiety medication 6/21/11 order for anxiety medication 6/21/11 order for pain relief medication 6/21/11 order for depression medication 6/22/11 order for medication change Monthly physician orders summary for June 2011 During record review for Resident #91, the monthly physician orders summary were unsigned by the physician for April 2011 and May 2011.		**alleged deficient practice. Residents #91, #104's identified orders & summary were dated and signed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?A 100% audit for the months of May, June and July 2011 orders and summaries of in-house residents was completed by July 22, 2011 by the RHIT. One finding was signed and dated by the physician. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All licensed nurses will be in-serviced on the following policies and procedures by the Director of Nursing on July 28 or August 1, 2011: General Policies and Month End/Re-Write protocol. Licensed Nurses will obtain required information during physician visits.The RHIT will do a month end audit of summaries and orders of those residents who were seen during the current month to ensure they are signed and dated.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administrator, Director of Nursing Services or designees will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During record review for Resident #91, the following physician orders were unsigned by the physician or nurse practitioner: 5/20/11 order for morphine 5/20/11 order for morphine 5/20/11 order for morphine 5/20/11 order for home health to provide care and pain management On 7/15/11 at 8:30 a.m., the Health Facility Administrator provided the undated "Month End/Re-write protocol" and indicated the policy was the one currently used by the facility. The policy included, "...have the physician sign the physician's orders...." On 7/15/11 at 8:30 a.m., the Health Facility Administrator provided the policy "General Policies," dated 8/2009, and indicated the policy was the one currently used by the facility. The policy indicated, "...Golden Years Homestead maintains complete and accurate medical records on each resident...In-house charts and discharged charts documentation shall be completed in a timely manner...Each individual order must be signed by the physician. Monthly Physician Orders should be signed and dated when the physicians make their rounds...."		monitor continued compliance through no less than monthly random chart audits x 6 months. The Administrator will document findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-22(c)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure 1 of 4 nursing staff washed hands while administering medications, potentially affecting 6 of 30 residents observed for	F0441	**This provider has an established Infection Control Program that maintains a program designed to provide a safe, sanitary and comfortable environment and helps prevent**	08/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the administration of medications. (Nurse #2, Resident #29, #40, #42, #44, #45, and #50). Findings include: During a continual observation of a medication pass on the B Unit (secured memory care unit) on 7/12/11 from 4:45 P.M. until 5:15 P.M., Nurse #2 was observed to pass medications to residents. At 4:45 P.M., Nurse #2 was observed in the dining room of Maple Cove (one "neighborhood" on the secured memory care unit) administering oral medications to Resident #29. The nurse was not observed to wash hands or to use hand sanitizer after administering the medications. Nurse #2 was then observed to leave Maple Cove and proceed through a set of secured doors and enter Hickory Ridge (another "neighborhood" on the secured memory care unit) to administer medications to the residents in that dining room. Nurse #2 was observed to administer oral medications to Resident #42, Resident #44, Resident #45, Resident #50, and Resident #40 while they were seated in the dining room. Nurse #2 was not observed to wash hands or to use hand gel at any time during this medication pass.		**the development and transmission of disease and infection. This provider's Infection Control Program also includes preventing the spread of infection and proper linen handling.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #29, #40, #42, #44, #45 and #50 had no negative outcomes as a result of the alleged deficient practice. Nurse #2 received one on one written training with the DNS and Community Nurse Leader on July 15, 2011. He has since resigned.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**All residents living in Community B had the potential to be affected by the alleged deficient practice. No negative outcomes occurred to any resident.All employees involved in medication administration and food service operations will be in-serviced by the Administrator, Culinary Services Advisor and Registered Dietician on July 26, July 28 or August 1 and August 2, 2011. In-Service topics will be: Alleged deficient practices identified, Proper Culinary Services hand washing policy and procedure, glove usage policy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nurse #7 was interviewed on 7/14/11 at 10:30 A.M. During the interview, Nurse #7 indicated nurses were to either use hand sanitizer or wash hands with soap and water before and after administering medications to residents and in between each resident contact. The facility Director of Nursing (DON) was interviewed on 7/14/11 at 11:00 A.M. During the interview, the DON indicated nurses were expected to use hand sanitizer or wash hands with soap and water while administering medications to residents. A facility policy entitled "Administration of Oral Medications", dated July 2011, indicated "wash hands before preparing medications for administration." 3.1-18(l)		procedure, including proper procedure when moving from a soiled area to a clean area, towel/rag usage, dress code policy and procedure to include no gum chewing. All employees will be also be in-serviced on Washing Hands with Alcohol Sanitizer and Indications for Hand Washing when Providing Direct Care to a resident Policies and Procedures. Return demonstrations will be required from all employees. All Licensed Nurses in-servicing will include all of the above topics and this provider's Oral Administration of Medications Policy and Procedure.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All employees including all licensed nurses will be trained on the topics listed above and will be randomly audited for proper policy and procedure compliance. Director of Nursing Services or designees** will provide on the job training and teaching to licensed nurses as individual needs are identified. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administrator, Director of Nursing Services or designees will monitor continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			compliance through no less than monthly random medication administration audits and employee observations regarding the topics trained during the in-services x 6 months. The Administrator will document findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	